twice, and 10 (28.6%) appeared 3 or more times. Within the nonphysician PhD cohort, all 6 women (100%) appeared only once compared with 20 men (87.0%).

Discussion | In this study of primetime programming on 3 major networks, physicians constituted only one-fifth of unique speakers and had less than one-third of speaking time on COVID-19 content. Women's voices were in the minority, including among physicians and nonphysicians with PhD degrees, with variability by network. The proportion of women speaking on COVID-19 content was no different from the proportion of women speaking on other content, suggesting that the paucity of female voices on cable news programs is not subject specific.

Limitations of the present study include the focus on binary gender, possible bias due to the observation window, and the small number of networks, shows, and time slots represented. Nevertheless, this study provides informative descriptive information on the representation of medical experts and gender gap in media representation during the COVID-19 pandemic. This inconsistency with the composition of the workforce could detract from the perceived legitimacy of female doctors amid a national crisis. Greater diversity of voices might enrich discourse.

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Outcomes of Universal COVID-19 Testing Following Detection of Incident Cases in 11 Long-term Care Facilities

Residents in long-term care facilities are at particularly high risk of infection and poor outcomes associated with coronavirus disease 2019 (COVID-19).[1,2] Early in the course of the pandemic, testing recommendations by the Centers for Disease Control advised testing residents and staff solely based on the presence of typical symptoms. Despite these efforts, there have been widespread outbreaks across long-term care facilities in the US, with high mortality rates.

Methods | We performed universal testing of untested residents across 11 Maryland long-term care facilities that (1) had previously undergone targeted testing through the local health department based on individual residents' symptoms and (2) had known positive cases. Nasopharyngeal swab samples were collected, and reverse transcriptase-polymerase chain reaction analysis was used to detect severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) RNA. Symptom status (any fever >99 °F, cough, diarrhea, respiratory decompensation, or other acute clinical status changes) at the time of universal testing was recorded based on discussion with facility staff. We used descriptive statistics to report the prevalence of positive test results and symptom status at the time of testing. Two-week telephone follow-up was conducted at 7 facilities following point-prevalence testing to obtain information regarding hospitalization and mortality status of all tested residents. This study was reviewed by the Johns Hopkins institutional review board and deemed exempt as public health surveillance activity.

Results | Targeted symptom-based testing identified 153 cases prior to point-prevalence surveys at 11 facilities within 20 days of detection of the index case. Among the remaining 893 residents who were universally tested, 354 (39.6%) tested positive for SARS-CoV-2 RNA. Thus, universal screening

Table 1. Results, Known Case Burden, and Timing of Testing by Facility

Facility	NH/ALF	Days between index case and testing	No. positive/No. tested (% positive)	Known resident cases prior to testing	Total No. of cases	No. (%) of asymptomatic cases
A	NH	5	114/151 (79.1)	26	140	65 (46.4)
B	NH	3	42/58 (72.4)	22	64	25 (39.1)
C	NH	12	29/39 (74.4)	34	63	29 (46.0)
D	NH	6	6/51 (11.8)	2	8	5 (62.5)
E	NH	10	53/104 (51.0)	34	87	53 (60.9)
F	NH	4	15/135 (11.1)	4	19	15 (78.9)
G	NH	4	16/105 (15.2)	13	29	16 (55.2)
H	NH	19	42/76 (55.3)	11	53	39 (73.6)
I	NH	9	14/143 (9.8)	3	17	14 (82.4)
J	ALF	7	6/12 (50.0)	2	8	4 (50.0)
K	ALF	7	17/19 (89.5)	2	19	16 (84.2)
Overall	81.8% NH		354/893 (39.6)	153	507	281 (55.4)

Abbreviations: ALF, assisted living facility; NH, nursing home.

Table 2. Two-Week Cumulative Hospitalization or Mortality Among Long-term Care Residents With Follow-up Data[a]

		Test result		
			Positive at testing	
Characteristic	Overall	Negative	Asymptomatic	Symptomatic
Total, No.	426	249	154	23
Hospitalized	33 (7.7)	9 (3.6)	20 (13.0)	4 (17.4)
Death	14 (3.3)	5 (2.0)	7 (4.6)	2 (8.7)

[a] Unless otherwise noted, data are number (percentage) of residents.

increased the total number of detected COVID-19 cases across all sites from 153 to 507; of these, 281 (55.4%) were asymptomatic (**Table 1**).

There was 2-week follow-up available for 426 of the residents tested at 7 facilities (177 positive for COVID-19, 249 negative). Among the 177 cases who were identified with universal testing, 154 (87.0%) were asymptomatic. Among those who tested positive and were asymptomatic at testing, 20 (13.0%) were hospitalized, and 7 (4.6%) died within 14 days of testing. Among the 23 residents who tested positive and were symptomatic at testing, 4 (17.4%) were hospitalized, and 2 (8.7%) died within 14 days of testing (**Table 2**).

Discussion | In this study of 11 Maryland long-term care facilities, an additional 354 cases (39.6% of those tested) were identified with universal testing, despite initial targeted, symptom-based testing. These results underscore the importance of universal testing because symptom-based approaches may miss a substantial number of cases.[2,3] Unrecognized asymptomatic cases among residents could perpetuate transmission within facilities.

According to data from the Center for Medicare & Medicaid Services, the overall case fatality among residents of long-term care facilities is about 33%.[4] The short-term mortality rate found in the present study among residents who underwent universal testing was much lower, suggesting that true COVID-associated mortality rates in long-term care facilities may be lowered by increased testing and case detection.

This study has limitations. Symptom status was only available at the time of testing and based on reports from facility staff. Follow-up data were only available for 7 of the 11 universally tested sites. Finally, there may be false negatives associated with nasopharyngeal swab samples.[5]

Long-term care facilities have emerged as "hot spots" for SARS-CoV-2 infection and mortality globally. Using symptom-based testing alone to identify positive residents is not adequate to assess case burden and inform outbreak-control efforts in these settings. Additional testing resources are urgently needed to identify the true burden of COVID-19 and curb transmission in long-term care settings.

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Association of Neighborhood Characteristics and Travel Patterns With Fatal Drug Overdoses

Fatal drug overdoses increased in US cities from 1999 through 2017.[1] Low-resource urban areas—popularly characterized as places where overdoses and drug trade thrive—are often considered self-contained, with residents considered the primary consumers of local drug markets.[2] There has been less discussion regarding inbound travel to such drug markets from nonresidents and which neighborhood characteristics may correspond with travel decisions. Targeting residents of overdose hot spots for intervention may reinforce stereotypes while excluding nonresident people who use drugs from treatment screening and delivery. We examined travel patterns between locations where fatal drug overdoses occurred and the home residences of the people who died plus the neighborhood-level characteristics that may have differed across these

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Supplemental content

Table 1. Univariable and Multivariable Logistic Regression Results for Odds of Far Travel Among 3927 Fatal Drug Overdoses in Cook County, Illinois, August 1, 2014, to December 31, 2018[a]

Variable	Unadjusted OR (95% CI)	*P* value[b]	Adjusted OR (95% CI)[c]	*P* value[b]
Age	0.98 (0.98-0.99)	<.001	0.99 (0.98-0.99)	<.001
Race/ethnicity[d]				
Non-Latino				
White	1 [Reference]			
Black	0.91 (0.78-1.05)	.20		
Latino	1.10 (0.88-1.37)	.39		
Other	0.63 (0.30-1.19)	.17		
Sex				
Female	1 [Reference]		1 [Reference]	
Male	1.28 (1.09-1.52)	.003	1.24 (1.03-1.48)	.02
Change in neighborhood disadvantage score from home to overdose zip codes[e]	1.94 (1.80-2.08)	<.001	1.43 (1.27-1.60)	<.001
Change in ICE from home to overdose zip codes[f]	0.20 (0.17-0.24)	<.001	0.47 (0.35-0.62)	<.001
Transit hub in home zip code				
No	1 [Reference]		1 [Reference]	
Yes	0.35 (0.30-0.41)	<.001	0.19 (0.15-0.24)	<.001
Transit hub in overdose zip code				
No	1 [Reference]		1 [Reference]	
Yes	1.27 (1.06-1.53)	.01	3.91 (3.03-5.08)	<.001

Abbreviations: ICE, index of concentration at the extremes; OR, odds ratio.

[a] The data source was the Cook County Open Data Medical Examiner Case Archive when accessed April 29, 2019 (https://datacatalog.cookcountyil.gov/Public-Safety/Medical-Examiner-Case-Archive/cjeq-bs86).

[b] *P* values were 2-sided, with values less than .05 considered significant.

[c] Adjusted for other covariates in the column (Akaike information criterion, 4068.1).

[d] There were no significant differences for racial/ethnic subcategories in univariable analysis, and these subcategories were not included in the adjusted model.

[e] Direction of travel dictates interpretation (eg, if a person traveled from a zip code of low deprivation [−5] to high deprivation [+5], the odds of far travel increased).

[f] Direction of travel dictates interpretation (eg, if a person traveled from a predominantly Black [−1] to a predominantly White [+1] zip code, the odds of far travel decreased).